Lymphogranuloma Venereum

1. DISEASE REPORTING

A. Purposes of Reporting and Surveillance

1. To assess trends in epidemic patterns, understand the impact of the burden of disease on populations, the health care infrastructure, and to better target population-level disease prevention efforts;
2. To assure the adequate treatment of infected individuals in order to reduce the duration of infectiousness and prevent sequelae of infection;
3. To identify cases in a timely fashion in order to interrupt the chain of infection through patient-level interventions such as management of sexual contacts and behavioral risk reduction counseling.

B. Legal Reporting Requirements

1. Health care providers: notifiable to local health jurisdiction within 3 work days
2. Hospitals: notifiable to local health jurisdiction within 3 work days
3. Laboratories: no requirements for reporting
4. Local health jurisdictions: notify the Washington State Department of Health (DOH), STD Services Section within 7 days of case investigation completion; summary information required within 21 days for all reported cases

C. Local Health Jurisdiction Investigation Responsibilities

1. Lymphogranuloma venereum cases should be reported using the STD Morbidity Report Form. (http://www.doh.wa.gov/LHJMap/LHJMap.htm)
2. Local health jurisdiction staff should initiate an investigation of the index patient within 3 working days of receiving a report indicative of a lymphogranuloma venereum case.
3. Local health jurisdiction staff should inform health care providers of the importance of instructing patients to refer sex partners for evaluation and treatment.

2. THE DISEASE AND ITS EPIDEMIOLOGY

A. Etiologic Agent

Chlamydia trachomatis serovars L1, L2 or L3.

B. Description of Illness

The disease is rare in the United States. Outbreaks have occurred among men who have sex with men (MSM). Women and MSM may have proctocolitis or inflammatory involvement of perirectal or perianal lymphatic tissues resulting in fistulas and strictures. A self-limited genital ulcer sometimes occurs at the site of inoculation.

C. Lymphogranuloma venereum in Washington State

During the past 10 years, six cases of lymphogranuloma venereum have been reported to DOH. Most cases occur among immigrants from, or travelers to, endemic areas.

D. Reservoir

Humans

E. Modes of Transmission

Direct contact with open lesions of infected people, usually during sexual intercourse.

F. Incubation Period

Incubation period is variable, with a range of 3-30 days for a primary lesion; if bubo is the first manifestation, 10 -30 days to several months.

G. Period of Communicability

Variable, from weeks to years during presence of active lesions.

H. Treatment

See CDC treatment guidelines at: http://www.cdc.gov/std/treatment

3. CASE DEFINITIONS

A. Clinical Criteria for Diagnosis

Infection with L1, L2, or, L3 serovars of *C. trachomatis* may result in a disease characterized by genital lesions, suppurative regional lymphadenopathy, or hemorrhagic proctitis. The infection is usually sexually transmitted.

B. Laboratory Criteria for Diagnosis

1. Isolation of *C. trachomatis*, serotype L1, L2, or L3 from clinical specimen, or
2. Demonstration by immunofluorescence of inclusion bodies in leukocytes of an inguinal lymph node (bubo) aspirate, or
3. Positive microimmunofluorescent serologic test for a lymphogranuloma venereum strain of *C. trachomatis*.

C. Case Definition

Probable: a clinically compatible case with one or more tender fluctuant inguinal lymph nodes or characteristic proctogenital lesions with supportive laboratory findings of a single *C. trachomatis* complement fixation titer of >64.

Confirmed: a clinically compatible case that is laboratory confirmed.

4. DIAGNOSIS AND LABORATORY SERVICES

A. Diagnosis

Diagnosis of lymphogranuloma venereum (LGV) is usually made serologically or by exclusion of other causes of inguinal lymphadenopathy or genital ulcers. Complement fixation titers > = 1:64 are consistent with the diagnosis of LGV.

B. Tests Available at PHL

Not available at the State laboratory

C. Criteria for Testing at PHL

Not applicable.

D. Specimen Collection

CDC will provide laboratory support for states that lack laboratory capacity to perform LGV diagnostic testing. For further information see: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5342a2.htm.

5. ROUTINE CASE INVESTIGATION

A. Evaluate the Diagnosis

Confirm diagnostic and laboratory results in Section 4.

B. Identify Source of Infection and Potentially Exposed Persons

Persons who have had sexual contact with a patient who has LGV within the 30 days before onset of the patient's symptoms, or after the onset of symptoms, should be examined, tested for urethral or cervical chlamydia infection and treated.

C. Environmental Evaluation

None

6. CONTROLLING FURTHER SPREAD

A. Infection Control Recommendations

1. Health care setting:

   Standard Precautions are a set of protocols designed to reduce the risk of (or prevent) transmission of pathogens. Standard precautions synthesize the major features of Universal (Blood and Body Fluid) Precautions (designed to reduce the risk of transmission of bloodborne pathogens) and Body Substance Isolation (designed to reduce the risk of transmission of pathogens from moist body substances). Under standard precautions blood, all body fluids, and all body substances of patients are considered potentially infectious (CDC, 1997).

2. General

   When used consistently and correctly, male latex condoms are effective in preventing the sexual transmission of STDs.

B. Case Management

See routine case management above.

C. Contact Management

See routine case management above.

D. Environmental Measures

7. MANAGING SPECIAL SITUATIONS

Call the Department of Health STD Services for special situations. (360 236-3460)

8. ROUTINE PREVENTION

A. Vaccine Recommendations

No vaccine currently exists for lymphogranuloma venereum.

B. Prevention Recommendations

Key individual STD prevention messages include:

Abstinence

Abstain from sex (do not have oral, anal, or vaginal sex) until you are in a relationship with only one person, are having sex with only each other, and each of you knows the other's STD, including HIV status.

If you have, or plan to have, more than one sex partner:

- Use a latex condom and lubricant every time you have sex.
- Get tested for asymptomatic STDs including HIV.
- If you are a man who has had sex with other men, get tested at least once a year.
- If you are a woman who is planning to get pregnant or who is pregnant, get tested for syphilis and HIV as soon as possible, before you have your baby. Ask your health care provider about being tested for other STDs.
- Talk about HIV and other STDs with each partner before you have sex.
- Learn as much as you can about each partner's past behavior (sex and drug use).
- Ask your partners if they have recently been treated for an STD or have been tested for HIV; encourage those who have not been tested to do so.
- Get vaccinated against hepatitis B virus.

Do not inject illicit drugs.

Drugs also affect your ability to make decisions, which may result in riskier sex.

If you do inject drugs, do the following:

- Use only clean needles, syringes, and other works.
- Never share needles, syringes, or other works.
- Be careful not to expose yourself to another person's blood.
- Get tested for HIV at least once a year.
- Consider getting counseling and treatment for your drug use.
- Get vaccinated against hepatitis A and B viruses.
- Do not have sex when you are taking drugs or drinking alcohol because being high can make you more likely to take risks.

Key prevention strategies include:

STD prevention counseling, testing, and referral services – Individuals at risk for STD should be offered counseling regarding methods to eliminate or reduce their risk and testing so that they can be aware of their status and take steps to protect their own health and that of their partners.

Partner Services (or Partner Notification) with strong linkages to prevention and treatment/care services – Sexual partners of STD-infected persons have been exposed to STD and are at-risk of being infected. Partner services locate these individuals based on information provided by the patient and provide counseling and education about the exposure as well as services to prevent infection or, if infected, linkages to care.

Prevention for high-risk populations – Prevention interventions for high-risk populations at high-risk or STDs, including HIV-infected persons, are critical to reducing the spread of STDs and HIV and ensure that those at highest risk of acquiring or transmitting these diseases are given the tools necessary to protect themselves and others from HIV infection. Prevention includes targeted health education and risk reduction, health communication programs, and public information programs for at-risk populations and the general public.

School-based STD Prevention – Schools have a critical role to play in promoting the health and safety of young people and helping them establish lifelong healthy behavior patterns. Washington State requires schools to teach medically accurate comprehensive sex education if such is provided by the school district.

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UPDATES